



# Clinical Quality Measures Workgroup

## Initial Performance Measure Catalog – Final July 2015

| Measure Name (and Source)   | Measure Description   | Rationale for the Measure   |
|---|---|---|
| Screening for clinical depression.  | Percentage of patients aged 12 years and older screened for clinical depression using a standardized tool and follow up plan documented.  | In Idaho, 22.5% of persons aged 18 or older had a mental illness and 5.8% had SMI in 2008–2009 while 7.5% of persons aged 18 or older had a major depressive episode (MDE). During the period 2005–2009, 9% of persons aged 12-17 had a past MDE. Suicide is the second leading cause of death for Idahoans aged 15–34 and for males aged 10–14.<br>This measure aligns with Healthy People 2020. |
| Measure pair: (a.) Tobacco use assessment.<br><br>(b.) Tobacco cessation intervention (SIM) | Percentage of patients who were queried about tobacco use one or more times during the two-year measurement period.<br><br>Percentage of patients identified as tobacco users who received cessation intervention during the two-year measurement period. | In Idaho, 16.9% of the adult population were smokers in 2010 (>187,000 individuals). Idaho ranks fifteenth in the country in prevalence of adult smokers and its smoking-attributable mortality rate is ranked eighth in the country.   |
| Asthma ED visits.   | Percentage of patients with asthma who have greater than or equal to one visit to the ED for asthma during the measurement period.  | While asthma prevalence (those with current asthma) in Idaho was 8.8% in 2010, reduction of emergency treatment for uncontrolled asthma is a reflection of high quality patient care and patient engagement.  |
| Acute care hospitalization (risk-adjusted).   | Percentage of patients who had to be admitted to the hospital.  | While Idaho has one of the country's lowest hospital admission rates (81/1000 in 2011), this measure is held as one of the standards for evaluation of utilization and appropriate use of hospital services as part of an integrated network.   |
| Readmission rate within 30 days.  | Percentage of patients who were readmitted to the hospital within 30 days of discharge from the hospital.   | Data currently unavailable. Metric will be used to establish baseline.  |
| Avoidable emergency care without hospitalization (risk-adjusted).                           | Percentage of patients who had avoidable use of a hospital ED.  | While Idaho has one of the country's lowest hospital ED utilization rates (327/1000, 2011), this measure is still held as one of the standards for evaluation of utilization and appropriate use of emergency services, as well as a reflection of quality and patient engagement in primary care related to avoidable treatment.   |

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|---|---|---|
| Elective delivery.  | Rate of babies electively delivered before full-term.   | Data currently unavailable. Metric will be used to establish baseline.  |
| Low birth weight rate (PQI 9).  | This measure is used to assess the number of low birth weight infants per 100 births.   | While Idaho's percentage of low birth weight babies is low compared to the national average, the opportunity to improve prenatal care across settings is an indicator of system quality.<br>1,355 babies in Idaho had low birth weights in 2011, compared to 1,160 in 1997.   |
| Adherence to antipsychotics for individuals with psychotic diagnoses. | The percentage of individuals 18–64 years of age during the measurement year with a psychotic diagnosis who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.  | Idaho has a 100% shortage of mental health providers statewide. Without these critical providers, there is little or no support for patient engagement and medication adherence.<br>Improved adherence may be a reflection of improved access to care and patient engagement. |
| Weight assessment and counseling for children and adolescents (SIM).  | Percentage of children, two through 17 years of age, whose weight is classified based on Body Mass Index (BMI), who receive counseling for nutrition and physical activity.   | In 2011, 13.4% of children were overweight as defined by being above the 85 <sup>th</sup> percentile, but below the 95 <sup>th</sup> percentile for BMI by age and sex, while 9.2% were obese, i.e., at or above the 95 <sup>th</sup> percentile for BMI by age and sex.      |
| Comprehensive diabetes care (SIM).                                    | The percentage of patients 18-75 with a diagnosis of diabetes, who have optimally managed modifiable risk factors (A1c<8.0%, LDL<100 mg/dL, blood pressure<140/90 mm Hg, tobacco non-use, and daily aspirin usage for patients with diagnosis of IVD) with the intent of preventing or reducing future complications associated with poorly managed diabetes. | Adult diabetes prevalence in 2010 was 8.0%. Overall, this represented one in 12 people in Idaho had diabetes.   |

| Measure Name (and Source)      | Measure Description   | Rationale for the Measure   |
|--------------------------------|---|---|
| Access to care.                | Members report adequate and timely access to PCPs, BEHAVIORAL HEALTH, and dentistry (measure adjusted to reflect shortages in Idaho).   | Idaho has a critical access shortage of primary care providers, behavioral health providers, and dentists across the State which impedes access to the appropriate level of care.               |
| Childhood immunization status. | Percentage of children two years of age who had four DtaP/DT, three IPV, one MMR, three H influenza type B, three hepatitis B, one chicken pox vaccine, and four pneumococcal conjugate vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates. | While there have been significant improvements in immunization rates, Idaho ranks 43rd in the nation with an immunization rate of 87.33% in 2012. This measure aligns with Healthy People 2020. |
| Adult BMI Assessment.          | The percentage of members 18 to 74 years of age who had an outpatient visit and who's BMI was documented during the measurement year or the year prior to the measurement year.   | In 2010, 62.9% of adults in Idaho were overweight, and 26.9% of adults in Idaho were obese.   |
| Non-malignant opioid use.      | Percent of patients chronically prescribed an opioid medication for non-cancer pain (defined as three consecutive months of prescriptions) that have a controlled substance agreement in force (updated annually).  | From 2010–2011, Idaho had the fourth highest non-medical use of prescription pain relievers in the country among persons aged 12 or older at 5.73%.   |

The timeline for developing a baseline and establishing performance reporting to achieve population health management is outlined below.

The IHC will establish a baseline for each of these measures in Year 1 of model testing.

Due to the lack of uniform reporting that exists today, the IHC will develop a baseline from the pockets of information that are currently available across payers and populations. An external organization with expertise in performance data collection, analysis, and reporting will assist the IHC in gathering and analyzing the data to establish a baseline by the end of Year 1.

In Year 2, the IHC will select four core performance measures from the initial Performance Measure Catalog to be reported by all PCMHs in Year 2.

The statewide performance measures for Year 2 will include the three SIM measures: tobacco cessation intervention, weight assessment and counseling for children and adolescents, and comprehensive diabetes care.

In consultation with the IHC, RCs will identify additional performance measures from the Performance Measure Catalog to be collected from PCMHs in their respective regions in Year 3.

The additional measures collected in Year 3 may vary from region to region depending on performance and regional health needs and will be informed by community health assessments and regional specific clinical data.

During the first year of implementation and model testing, the IHC will analyze the current system capabilities and constraints regarding statewide data collection and reporting. By the end of Year 1, decisions regarding construction of the statewide database and protocols for PCMHs to report on performance measures will have been developed. The IHC will engage stakeholders in this discussion to ensure that a statewide solution is viable and acceptable to the different communities in Idaho.

The development of a Performance Measure Catalog and reporting of statewide performance measures across multiple payers and populations is a major first step for Idaho as we move toward population health management.